STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L014	A. BUILDING _____ B. WING _____	C 04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments	N 000	By submitting this Plan of Correction, the Facility does not admit that it violated the regulations. The Facility also reserves the right to amend the Plan of Correction as necessary and to contest the deficiencies, findings, conclusions, and actions of the agency. Immediately following the survey, the CEO and senior management met and developed and planned a course of action to address any identified deficiencies.	
	An unannounced complaint survey. CCR# 2016003021 was commenced on and concluded on at Sandy Pines Residential Treatment Facility for Children and Adolescents. The allegations were substantiated. The facility is not in compliance with 42 CFR Part 483.354, Subpart G, Requirements for Residential Treatment Facilities for Children and Adolescents. The Condition level deficiency was identified to be out of compliance, 42 CFR Part 483.354 Use Of And (N0100). Seventeen standard level deficiencies were identified to be out of compliance, N0125, N0140, N0145, N0149, N0152, N0153, N0154, N0155, N0160, N0161, N0174, N0178, N0188, N0189, N0196, N0202 and N0222. The effect of the systematic practices resulted in the facility's inability to ensure the provision of quality health care to their residents.			
N 100	483.354 USE OF AND Subpart G: Condition of Participation for the Use of and In Residential Treatment Facilities Providing Inpatient Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to comply with the regulations related to and to: Assure that the policies and procedures were clear related to who was authorized to order a	N 100	Please see responses to N 125, N 140, N 145, N 149, N152, N 153, N 154, N 155, N 160, N 161, N 174, N 178, N 188, N 189, N 196, N 202, and N 222	

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MAY 06 2016
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/8/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are corrected, an approved plan of correction is requisite to continued program participation.

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N 100	Continued From page 1 and/or (Refer to N0125); Assure that orders for were in place for the intervention (Refer to N0140); Assure that an assessment was performed by a qualified person one hour after the or (Refer to N0145); Assure that a and a were documented (Refer to N0149); Assure that the result of a Registered Nurse assessment was documented (Refer to N0152); Assure that seclusions were documented (Refer to N0153); Assure that the names of the staff involved in seclusions were documented (Refer to N0154); Assure that seclusions and outcomes were documented (Refer to N0155); Assure that the physician was consulted for seclusions (Refer to N0160); Assure that the date and time of seclusions were documented (Refer to N0161); Assure that the residents were evaluated after the use of the (Refer to N0174); Assure that notification of seclusions was conducted (Refer to N0178); Assure that the post interventions debriefings were conducted after and (Refer to N0188); Assure that the staff debriefing was conducted timely (Refer to N0189); Assure that residents received treatment for injuries resulting from (Refer to N0196); Assure that staff involved in that resulted in injuries and supervisory staff met, related to the injuries (Refer to N0202) and Assure that staff performing the and seclusions received training on and seclusions on a semiannual basis (Refer to N0222)	N 100		

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N 100	Continued From page 2 The effect of the systematic practices resulted in the facility's inability to ensure the provision of quality health care to their residents.	N 100		
N 125	483.356 (a) PROTECTION OF RESIDENTS and policy for the protection of residents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have policies and procedures for the use of and that clearly defined who was able to authorize the use of and . The findings included: Review on of the facility's policies and procedures titled, " and " with the most recent review of , revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation [...]". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." In a telephone interview conducted on at 3:03 PM with the facility's Risk Manager, the	N 125	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.	, 2016

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N 100	Continued From page 2 The effect of the systematic practices resulted in the facility's inability to ensure the provision of quality health care to their residents.	N 100	**N 125 Continued** - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of . - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.	
N 125	483.356 (a) PROTECTION OF RESIDENTS and policy for the protection of residents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have policies and procedures for the use of and that clearly defined who was able to authorize the use of and . The findings included: Review on of the facility's policies and procedures titled, " and " with the most recent review of , revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation [...]". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." In a telephone interview conducted on at 3:03 PM with the facility's Risk Manager, the	N 125		

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N 100	Continued From page 2 The effect of the systematic practices resulted in the facility's inability to ensure the provision of quality health care to their residents.	N 100	**N 125 Continued** - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / The DON and and revised all medical records forms related to the documentation of the use of / to ensure that all required elements could be documented correctly and thoroughly.	, 2016
N 125	483.356 (a) PROTECTION OF RESIDENTS and policy for the protection of residents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have policies and procedures for the use of and that clearly defined who was able to authorize the use of and . The findings included: Review on of the facility's policies and procedures titled, " and " with the most recent review of , revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation [...]". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." In a telephone interview conducted on at 3:03 PM with the facility's Risk Manager, the	N 125	The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: - Definition of and appropriate justification for use of and/or during for an emergency safety situation - Revisions/clarifications to the / Policy including: • Who may authorize the use of and/or • Requirement to obtain a physician's order for any use of and/or • Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or • Requirement to fully document each use of and/or	, 2016

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N 100	Continued From page 2 The effect of the systematic practices resulted in the facility's inability to ensure the provision of quality health care to their residents.	N 100	**N 125 Continued** • Requirement to document in the medical record, the emergency safety situation that required/justified the use of ..... and/or , the interventions used, and the outcome of the intervention • Requirement to document the names of all staff involved in the ..... and/or • Need to consult with the resident's treatment team physician for the and ..... and to document that consultation including the date/time of the consult. • Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation • Need to notify the resident's legal guardian that the resident had a ..... and/or and document that notification • Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of ,	
N 125	483.356 (a) PROTECTION OF RESIDENTS and policy for the protection of residents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have policies and procedures for the use of and that clearly defined who was able to authorize the use of and . The findings included: Review on of the facility's policies and procedures titled, " and " with the most recent review of , revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation [...]". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." In a telephone interview conducted on at 3:03 PM with the facility's Risk Manager, the	N 125		

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N 100	Continued From page 2 The effect of the systematic practices resulted in the facility's inability to ensure the provision of quality health care to their residents.	N 100	**N 125 Continued** • Requirement to complete and document a debriefing session within 24 hours after use of rest int and/or seclusion with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. • Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / . - Revisions to the / forms - Documentation requirements related to / - Expectations for full compliance to the / policy and documentation requirements.	
N 125	483.356 (a) PROTECTION OF RESIDENTS and policy for the protection of residents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have policies and procedures for the use of and that clearly defined who was able to authorize the use of and . The findings included: Review on of the facility's policies and procedures titled, " and " with the most recent review of , revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation [...]". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." In a telephone interview conducted on at 3:03 PM with the facility's Risk Manager, the	N 125		

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N 100	Continued From page 2 The effect of the systematic practices resulted in the facility's inability to ensure the provision of quality health care to their residents.	N 100	**N 125 Continued**	
N 125	483.356 (a) PROTECTION OF RESIDENTS and policy for the protection of residents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have policies and procedures for the use of and that clearly defined who was able to authorize the use of and . The findings included: Review on of the facility's policies and procedures titled, " and " with the most recent review of , revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation [...]". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." In a telephone interview conducted on at 3:03 PM with the facility's Risk Manager, the	N 125	Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work. **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate.	, 2016 and ongoing

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N 100	Continued From page 2 The effect of the systematic practices resulted in the facility's inability to ensure the provision of quality health care to their residents.	N 100	**N 125 Continued**	
N 125	483.356 (a) PROTECTION OF RESIDENTS Restraint and policy for the protection of residents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have policies and procedures for the use of and that clearly defined who was able to authorize the use of and . The findings included: Review on of the facility's policies and procedures titled, " and ." with the most recent review of , revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation [...]". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." In a telephone interview conducted on at 3:03 PM with the facility's Risk Manager, the	N 125	For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented seclusion/ to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	

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N 125	Continued From page 3 facility's Risk Manager explained that the policy was intended to clarify that other staff were not allowed to use or seclusions without a nurse's involvement.	N 125		
N 140	483.358(a) ORDERS FOR USE OF OR Orders for or must be by a physician, or other licensed practitioner permitted by the State and the facility to order or and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient services for beneficiaries under are provided under the direction of a physician. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to obtain a physician's order for the use of for 2 of 17 sampled residents reviewed for seclusions and (Resident #16 and #17). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation [...]". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If	N 140	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of " and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or	May 3, 2016

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N 140	Continued From page 4 the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines; The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked; they were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record, on revealed that the resident was admitted to the facility on . The record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers	N 140	**N 140 Continued** - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / .	

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N 140	Continued From page 4	N 140	**N 140 Continued**	

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Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines; The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked; they were observed pacing back and forth in the area and this lasted at least 5 minutes.

Review of Resident #16's record, on revealed that the resident was admitted to the facility on . The record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers

- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of /seclusion. If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / .

The DON and and revised all medical records forms related to the documentation of the use of / to ensure that all required elements could be documented correctly and thoroughly. , 2016

The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: , 2016

- Definition of and appropriate justification for use of and/or during for an emergency safety situation
- Revisions/clarifications to the Restraint/Seclusion Policy including:

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N 140	Continued From page 4	N 140	**N 140 Continued**	

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Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies.

Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines; The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked; they were observed pacing back and forth in the area and this lasted at least 5 minutes.

Review of Resident #16's record, on revealed that the resident was admitted to the facility on . The record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers

- Who may authorize the use of and/or
- Requirement to obtain a physician's order for any use of and/or
- Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
- Requirement to fully document each use of and/or
- Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention
- Requirement to document the names of all staff involved in the and/or
- Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification

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Review on of the facility's own video recording revealed Residents #18 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines; The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked; they were observed pacing back and forth in the area and this lasted at least 5 minutes.

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- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint/seclusion.
- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /

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N 140	Continued From page 5 and was not responding to redirection. The resident's record further revealed evidence of documentation that the facility discharged the resident, at that time. Continued review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's record, no evidence of documentation that the facility obtained a physician's order for the on . 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's record, including no evidence of documentation that the facility obtained a physician's order for the of . In an interview conducted on at 12:03 PM with the facility's own Risk Manager, the facility's own Risk Manager reported that the facility was a locked facility and the units were also locked and she inquired whether this was a .	N 140	**N 140 Continued** For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	
N 145	483.358(f) ORDERS FOR USE OF OR	N 145		

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N 145 Continued From page 6

Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and wellbeing of residents, must conduct a face-to-face assessment of the physical and wellbeing of the resident, including but not limited to-

(1) The resident's physical and status;

(2) The resident's behavior;

(3) The appropriateness of the intervention measures; and

(4) Any complications resulting from the intervention.

This ELEMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to have a Registered Nurse or Physician conduct a face to face assessment of the resident, to include the required assessments, within one hour of the initiation of a for 2 of 17 sampled residents reviewed for and (Resident #16 and #17).

The findings included:

1. Review on / / of the facility's policies and procedures titled, " and " with the most recent review of / / revealed that the policies and procedures documented that a Registered Nurse (RN) conduct a face to face assessment of the resident within an hour of the

N 145 **N 145 Continued**

- Need to notify the resident's legal guardian that the resident had a and/or and document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /
- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / , if an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /

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N 145	Continued From page 6	N 145	**N 145 Continued**	

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(1) The resident's physical and status;

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The findings included:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR ...EDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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N 145	Continued From page 7 Initiation of a or Observations conducted on / at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on / at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on / / of the facility's own video recording revealed Residents #16 and #17 on / at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on / / revealed evidence of documentation that the resident was admitted to the facility on / /. The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on / accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed	N 145	**N 145 Continued** prevent further use of /seclusion. If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. • Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / . - Revisions to the Restraint/Seclusion forms - Documentation requirements related to / - Expectations for full compliance to the Restraint/ policy and documentation requirements. Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.	

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N 145	Continued From page 8 no evidence of documentation that staff documented the ( ) intervention in the resident's record, including no evidence of documentation that a RN conducted a face to face assessment of the resident within one hour of the initiation of the to include the required assessments. 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's record, including no evidence of documentation that a RN conducted a face to face assessment of the resident within one hour of the initiation of the to include the required assessments. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the facility's Risk Manager reported that the facility was a locked facility and the units were also locked and she inquired whether this was a	N 145	**N 145 Continued** **Monitoring:** The DON/designees and/or the RM review 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	May 8, 201 and ongoing
N 149	483.358(h) ORDERS FOR USE OF OR Staff must document the intervention in the resident's record. That documentation must be	N 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L014	A. BUILDING _____ B. WING _____	C 04/08/2016

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N 149	Continued From page 9 completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following: This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document a in the resident's record for 2 of 17 sampled residents reviewed for (Resident #16 and #17) and failed to document a in the resident's record for 1 of 17 sampled residents reviewed for (Resident #5). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for / " packet for each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to	N 149	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.	, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 149	Continued From page 9	N 149	N 149 Continued	

completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

This ELEMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to document a in the resident's record for 2 of 17 sampled residents reviewed for seclusions (Resident #16 and #17) and failed to document a in the resident's record for 1 of 17 sampled residents reviewed for (Resident #5).

The findings included:

1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for Restraint/Seclusion" packet for each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to

- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /

The DON and and revised all medical records forms related to the documentation of the use of /seclusion to ensure that all required elements could be documented correctly and thoroughly. , 2016

The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: , 2016

- Definition of and appropriate justification for use of and/or during for an emergency safety situation
- Revisions/clarifications to the / Policy including:
  - Who may authorize the use of and/or
  - Requirement to obtain a physician's order for any use of and/or
  - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
  - Requirement to fully document each use of and/or
  - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention

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N 149	Continued From page 9	N 149	**N 149 Continued**	

completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

This ELEMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to document a in the resident's record for 2 of 17 sampled residents reviewed for (Resident #16 and #17) and failed to document a in the resident's record for 1 of 17 sampled residents reviewed for (Resident #5).

The findings included:

1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for / " packet for each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to

- Requirement to document the names of all staff involved in the and/or
- Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /seclusion.

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N 149	Continued From page 9	N 149	**N 149 Continued**	

completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

This ELEMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to document a in the resident's record for 2 of 17 sampled residents reviewed for (Resident #16 and #17) and failed to document a in the resident's record for 1 of 17 sampled residents reviewed for (Resident #5).

The findings included:

1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for /Seclusion" packet for each episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two rooms, with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to

- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /

- Revisions to the / forms
- Documentation requirements related to restraint/seclusion
- Expectations for full compliance to the Restraint/Seclusion policy and documentation requirements.

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N 149	Continued From page 9	N 149	N 149 Continued	

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This ELEMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to document a in the resident's record for 2 of 17 sampled residents reviewed for (Resident #16 and #17) and failed to document a in the resident's record for 1 of 17 sampled residents reviewed for (Resident #5).

The findings included:

1. Review on of the facility's own policies and procedures titled, " and ," with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for / " packet for each seclusion/ episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.

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N 149	Continued From page 9 completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following: This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document a in the resident's record for 2 of 17 sampled residents reviewed for (Resident #16 and #17) and failed to document a in the resident's record for 1 of 17 sampled residents reviewed for (Resident #5). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for Restraint/ " packet for each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to	N 149	**N 149 Continued** **Monitoring:** The DON/designees and/or the RM review 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	, 201 and ongoin

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 149	Continued From page 10 the to avoid , but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence of documentation that staff documented the intervention in the resident's record. 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after	N 149	**N 149 Continued** - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.	

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N 149	Continued From page 11 the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the intervention in the resident's record. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the facility's Risk Manager reported that the facility was a locked facility and the units were also locked and she inquired whether this was a 3. Review on of Resident #5's record revealed evidence of documentation of a on at 3:30 PM and the resident accused staff of spitting on the resident. The resident's record revealed evidence of documentation of a "monthly district staffing," dated that documented the resident was "restrained yesterday" and no additional information/packet documentation related to the intervention. During a review on at approximately 4:45 PM, of the facility's video recording of the occurrence and interview with the facility's Risk Manager, the facility's Risk Manager reported that she could not locate any video recording of the occurrence or additional information. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the facility's Risk Manager acknowledged the finding.	N 149		
N 152	483.358(h)(3) ORDERS FOR USE OF OR	N 152		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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N 152	Continued From page 12 [Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section. This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to have a Registered Nurse or Physician conduct a face to face assessment of the resident within one hour of the initiation of a to include the required time and results of the assessment, for 2 of 17 sampled residents reviewed for and (Resident #16 and #17). The findings included: Review on / / of the facility's policies and procedures titled, " and " with the most recent review of / / revealed that the policies and procedures documented a Registered Nurse (RN) to conduct a face to face assessment of the resident within an hour of the initiation of a or . Observations conducted on / / at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on / / at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies. Review on / / of the facility's own video recording revealed Residents #16 and #17 on / / at approximately 5:00 PM, locked away	N 152	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of " and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.	, 2016

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N 152	Continued From page 12	N 152	**N 152 Continued**	

[Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section.

This ELEMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to have a Registered Nurse or Physician conduct a face to face assessment of the resident within one hour of the initiation of a to include the required time and results of the assessment, for 2 of 17 sampled residents reviewed for and (Resident #16 and #17).

The findings included:

Review on of the facility's policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to conduct a face to face assessment of the resident within an hour of the initiation of a or .
Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies.
Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away

- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /
- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /seclusion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L014	A. BUILDING _____ B. WING _____	C 04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

N 152 Continued From page 12

[Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section.

This ELEMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to have a Registered Nurse or Physician conduct a face to face assessment of the resident within one hour of the initiation of a to include the required time and results of the assessment, for 2 of 17 sampled residents reviewed for and (Resident #16 and #17).

The findings included:

Review on of the facility's policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to conduct a face to face assessment of the resident within an hour of the initiation of a or .
Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies.
Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away

N 152

N 152 Continued

The DON and RM reviewed and revised all medical records forms related to the documentation of the use of /seclusion to ensure that all required elements could be documented correctly and thoroughly.

The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on:

- Definition of and appropriate justification for use of and/or during for an emergency safety situation
- Revisions/clarifications to the / Policy including:
  - Who may authorize the use of and/or
  - Requirement to obtain a physician's order for any use of and/or
  - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
  - Requirement to fully document each use of and/or
  - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention
  - Requirement to document the names of all staff involved in the and/or

, 201

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 152	Continued From page 12 [Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section. This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to have a Registered Nurse or Physician conduct a face to face assessment of the resident within one hour of the initiation of a to include the required time and results of the assessment, for 2 of 17 sampled residents reviewed for and (Resident #16 and #17). The findings included: Review on of the facility's policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to conduct a face to face assessment of the resident within an hour of the initiation of a or Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away	N 152	**N 152 Continued** • Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. • Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation • Need to notify the resident's legal guardian that the resident had a and/or and document that notification • Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /seclusion.	

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N 152	Continued From page 12	N 152	N 152 Continued	

[Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section.

This ELEMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to have a Registered Nurse or Physician conduct a face to face assessment of the resident within one hour of the initiation of a to include the required time and results of the assessment, for 2 of 17 sampled residents reviewed for and (Resident #16 and #17).

The findings included:

Review on of the facility's policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to conduct a face to face assessment of the resident within an hour of the initiation of a or
Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies.
Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away

- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of /seclusion. If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /
- Revisions to the / forms
- Documentation requirements related to /seclusion
- Expectations for full compliance to the / policy and documentation requirements.

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N 152 Continued From page 12

[Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section.

This ELEMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to have a Registered Nurse or Physician conduct a face to face assessment of the resident within one hour of the initiation of a to include the required time and results of the assessment, for 2 of 17 sampled residents reviewed for and (Resident #16 and #17).

The findings included:

Review on of the facility's policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to conduct a face to face assessment of the resident within an hour of the initiation of a or .
Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies.
Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away

N 152 **N 152 Continued**

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.

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N 152	Continued From page 13 from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on / / revealed evidence of documentation that the resident was admitted to the facility on / / . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on / accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's record, including no evidence of documentation that a RN conducted a face to face assessment of the resident within one hour of the initiation of the , to include the required time and results of the assessment. 2. Review of Resident #17's record on / / revealed that the resident was admitted to the facility on / / . The resident's record documented that the facility sent the resident to a receiving facility on / accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The	N 152	**N 152 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of /seclusion on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented seclusion/ to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	8, 2016 and ongoing

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N 152	Continued From page 14 resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's record, including no evidence of documentation that a RN conducted a face to face assessment of the resident within one hour of the initiation of the , to include the required time and results of the assessment. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a .	N 152		
N 153	483.358(h)(4) ORDERS FOR USE OF OR [Documentation must include] the emergency safety situation that required the resident to be restrained or put in . This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document the emergency safety situation that required the of 2 of 17 sampled residents reviewed for and (Resident #16 and #17). The findings included: Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a	N 153	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or	, 2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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N 153	Continued From page 15 Registered Nurse (RN) to "complete the Justification for Restraint/ packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for Restraint/Seclusion" sample document on revealed that the document required staff to complete the "Nursing Note/Rational/Justification for ( )Intervention" section of the packet. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on	N 153	**N 153 Continued** - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /	

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N 153	Continued From page 15 Registered Nurse (RN) to "complete the Justification for Restraint/Seclusion packet on each seclusion/ episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for Restraint/Seclusion" sample document on revealed that the document required staff to complete the "Nursing Note/Rational/Justification for (seclusion)Intervention" section of the packet. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on	N 153	N 153 Continued - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of restraint/ . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / . The DON and and revised all medical records forms related to the documentation of the use of /seclusion to ensure that all required elements could be documented correctly and thoroughly. , 2016 The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: May 8, 2016 - Definition of and appropriate justification for use of and/or during for an emergency safety situation - Revisions/clarifications to the Restraint/Seclusion Policy including: • Who may authorize the use of and/or	

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N 153	Continued From page 15	N 153	N 153 Continued	

Registered Nurse (RN) to "complete the Justification for / packet on each seclusion/ episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for / " sample document on revealed that the document required staff to complete the "Nursing Note/Rational/Justification for (seclusion)/intervention" section of the packet.

Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies.

Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes.

Review of Resident #16's record on

- Requirement to obtain a physician's order for any use of and/or
- Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
- Requirement to fully document each use of and/or
- Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention
- Requirement to document the names of all staff involved in the and/or
- Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification

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N 153	Continued From page 15	N 153	N 153 Continued	

Registered Nurse (RN) to "complete the Justification for / packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place."
Review of the "Justification for /Seclusion" sample document on revealed that the document required staff to complete the "Nursing Note/Rational/Justification for (seclusion)Intervention" section of the packet.
Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two rooms, with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies.
Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes.
Review of Resident #16's record on

- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /
- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of restraint/seclusion

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N 153	Continued From page 15	N 153	N 153 Continued	

Registered Nurse (RN) to "complete the Justification for Restraint/Seclusion packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for / " sample document on revealed that the document required staff to complete the "Nursing Note/Rational/Justification for (seclusion)Intervention" section of the packet. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on

- Revisions to the / forms
- Documentation requirements related to /
- Expectations for full compliance to the / policy and documentation requirements.

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L014	A. BUILDING _____ B. WING _____	C 04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 153	Continued From page 16 revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence of documentation that staff documented the emergency safety situation that required the intervention in the resident's record. 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the emergency safety situation that required the intervention in the resident's record. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a	N 153	**N 153 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented seclusion/ to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	, 201 and ongoin
N 154	483.358(h)(5) ORDERS FOR USE OF OR	N 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 154	Continued From page 17	N 154		

[Documentation must include] the name of staff involved in the emergency safety intervention.

This ELEMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to document in the resident's records the names of the staff members involved in a for 2 of 17 sampled residents reviewed for and (Resident #16 and #17).

The findings included:

1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for /Seclusion packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for / " sample document on revealed that the document required staff to document the names of the participants in the intervention.

Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately

Corrective Actions:

The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include:

- Clarification on the definition of and
- Who may authorize the use of and/or
- Requirement to obtain a physician's order for any use of and/or
- Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
- Requirement to fully document each use of and/or
- Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention
- Requirement to document the names of all staff involved in the and/or
- Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.

, 2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 154	Continued From page 17 [Documentation must include] the name of staff involved in the emergency safety intervention. This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document in the resident's records the names of the staff members involved in a for 2 of 17 sampled residents reviewed for and (Resident #16 and #17). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for / packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for Restraint/Seclusion" sample document on revealed that the document required staff to document the names of the participants in the intervention. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately	N 154	**N 154 Continued** - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /	

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N 154	Continued From page 17 [Documentation must include] the name of staff involved in the emergency safety intervention. This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document in the resident's records the names of the staff members involved in a for 2 of 17 sampled residents reviewed for and (Resident #16 and #17). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for Restraint/ packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for /Seclusion" sample document on revealed that the document required staff to document the names of the participants in the intervention. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately	N 154	N 154 Continued The DON and RM reviewed and revised all medical records forms related to the documentation of the use of / to ensure that all required elements could be documented correctly and thoroughly. The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: - Definition of and appropriate justification for use of and/or during for an emergency safety situation - Revisions/clarifications to the Restraint/Seclusion Policy including: • Who may authorize the use of and/or • Requirement to obtain a physician's order for any use of and/or • Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or • Requirement to fully document each use of and/or • Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention • Requirement to document the names of all staff involved in the and/or	May 4, 2016 8, 2016

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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N 154	Continued From page 17 [Documentation must include] the name of staff involved in the emergency safety intervention. This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document in the resident's records the names of the staff members involved in a for 2 of 17 sampled residents reviewed for seclusions and (Resident #16 and #17). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for Restraint/Seclusion packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for Restraint/ " sample document on revealed that the document required staff to document the names of the participants in the intervention. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately	N 154	**N 154 Continued** • Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. • Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation • Need to notify the resident's legal guardian that the resident had a and/or and document that notification • Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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N 154	Continued From page 17 [Documentation must include] the name of staff involved in the emergency safety intervention. This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document in the resident's records the names of the staff members involved in a for 2 of 17 sampled residents reviewed for seclusions and (Resident #16 and #17). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for / packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for /Seclusion" sample document on revealed that the document required staff to document the names of the participants in the intervention. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately	N 154	**N 154 Continued** • Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. • Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / - Revisions to the /Seclusion forms - Documentation requirements related to / - Expectations for full compliance to the / policy and documentation requirements.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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N 154	Continued From page 17 [Documentation must include] the name of staff involved in the emergency safety intervention. This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document in the resident's records the names of the staff members involved in a for 2 of 17 sampled residents reviewed for and (Resident #16 and #17). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for Restraint/Seclusion packet on each seclusion/ episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for " sample document on revealed that the document required staff to document the names of the participants in the intervention. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately	N 154	N 154 Continued Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.	

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N 154	Continued From page 18 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence of documentation that staff documented the intervention in the resident's record to include the names of the staff members involved in the . 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on	N 154	**N 154 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and are conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	, 2016 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 154	Continued From page 19 accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the intervention in the resident's record to include the names of the staff members involved in the . In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a .	N 154		
N 155	483.358(i) ORDERS FOR USE OF OR The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document in the resident's records that the resident had an emergency safety situation , the interventions used and the outcome for 2 of 17 sampled residents reviewed for seclusions and (Resident #16 and #17). The findings included: Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a	N 155	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or	, 2016

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N 155	Continued From page 20 Registered Nurse (RN) to "complete the Justification for / packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for /Seclusion" sample document on revealed that the document required staff to document the and its outcome. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the	N 155	**N 155 Continued** - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /	

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SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 155	Continued From page 20	N 155	N 155 Continued	

Registered Nurse (RN) to "complete the Justification for Restraint/ packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place."
Review of the "Justification for Restraint/ " sample document on revealed that the document required staff to document the and its outcome.

Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies.
Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes.
Review of Resident #16's record on revealed evidence of documentation that the

- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /

The DON and and revised all , 2016
medical records forms related to the documentation of the use of /
to ensure that all required elements could be documented correctly and thoroughly.

The DON, , and designees, along with , 2016
Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on:

- Definition of and appropriate justification for use of and/or during for an emergency safety situation

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N 155 Continued From page 20

Registered Nurse (RN) to "complete the Justification for /Seclusion packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for Restraint/Seclusion" sample document on revealed that the document required staff to document the and its outcome.

Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies.

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Review of Resident #16's record on revealed evidence of documentation that the

N 155

N 155 Continued

- Revisions/clarifications to the / Policy including:
  - Who may authorize the use of and/or
  - Requirement to obtain a physician's order for any use of and/or
  - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
  - Requirement to fully document each use of and/or
  - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention
  - Requirement to document the names of all staff involved in the and/or
  - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.
  - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation

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N 155 Continued From page 20

Registered Nurse (RN) to "complete the Justification for / packet on each /restraint episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place."
Review of the "Justification for /Seclusion" sample document on revealed that the document required staff to document the and its outcome.

Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies.
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Review of Resident #16's record on revealed evidence of documentation that the

N 155

N 155 Continued

- Need to notify the resident's legal guardian that the resident had a and/or and document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /
- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of restraint/seclusion. If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /

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N 155 Continued From page 20

Registered Nurse (RN) to "complete the Justification for / packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for / " sample document on revealed that the document required staff to document the and its outcome.

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N 155 **N 155 Continued**

- Revisions to the Restraint/Seclusion forms
- Documentation requirements related to restraint/seclusion
- Expectations for full compliance to the / policy and documentation requirements.

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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N 155	Continued From page 21 resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence of documentation that staff documented the emergency safety situation , in the resident's record to include the interventions used and the outcome. 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the emergency safety situation in the resident's record to include the interventions used and the outcome. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility, the units were also locked and she inquired whether this was a	N 155	**N 155 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	, 2016 and ongoing
N 160	483.360 CONSULTATION WITH TREATMENT	N 160		

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N 160	Continued From page 22 TEAM PHYSICIAN If a physician or other licensed practitioner permitted by the state and the facility to order or orders the use of or , that person must contact the resident's treatment team physician, unless the ordering physician is in fact the resident's treatment team physician. The person ordering the use of or must- (a) Consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in ; and This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to consult with the residents' treatment team physician for the use of a for 2 of 17 sampled residents reviewed for and , (Resident #16 and #17). The findings included: Review on of the facility's policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for / packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for /Seclusion" sample document on	N 160	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager (RM) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or seclusion - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and to document that consultation including the date/time of the consult.	May 3, 2016

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N 160	Continued From page 23 revealed that the document required staff to record the date and time the resident's primary physician was notified. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the	N 160	**N 160 Continued** - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of restraint/seclusion. If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of restraint/seclusion.	

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N 160	Continued From page 23	N 160	N 160 Continued	, 2016

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The DON and and revised all medical records forms related to the documentation of the use of /seclusion to ensure that all required elements could be documented correctly and thoroughly.

, 2016

The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on:

- Definition of and appropriate justification for use of and/or during for an emergency safety situation
- Revisions/clarifications to the /Seclusion Policy including:
  - Who may authorize the use of and/or
  - Requirement to obtain a physician's order for any use of and/or
  - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
  - Requirement to fully document each use of and/or
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N 160 N 160 Continued

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- Revisions to the Restraint/ forms
- Documentation requirements related to /
- Expectations for full compliance to the /policy and documentation requirements.

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N 160	Continued From page 23	N 160	N 160 Continued	

revealed that the document required staff to record the date and time the resident's primary physician was notified.
Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies.
Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes.
Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L014	A. BUILDING _____ B. WING _____	C 04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

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N 160	Continued From page 24 facility discharged the resident at that time. Further review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's record, including evidence of consulting with the resident's treatment team physician for the use of a . 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's record, including evidence of consulting with the resident's treatment team physician for the use of a . In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a .	N 160	N 160 Continued Monitoring: The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. Responsible: Director of Nursing	, 2016 and ongoing
N 161	483.360(b) CONSULTATION WITH TREATMENT TEAM PHYSICIAN The person ordering the use of or must- 483.360(b) Document in the resident's record the	N 161		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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N 161	Continued From page 25 date and time the team physician was consulted. This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document, in the resident's record, the date and time the team physician was consulted for the use of a for 2 of 17 sampled residents reviewed for seclusions and , (Resident #16 and #17). The findings included: Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for /Seclusion packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for / " sample document on revealed that the document required staff to record the date and time the team physician was notified. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies.	N 161	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of " and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and to document that consultation including the date/time of the consult.	, 2016

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N 161	Continued From page 26 Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including that staff documented the date and time the team physician was consulted for the use of a intervention. 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after	N 161	**N 161 Continued** - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / .	

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N 161	Continued From page 26 Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including that staff documented the date and time the team physician was consulted for the use of a intervention. 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after	N 161	N 161 Continued The DON and and revised all medical records forms related to the documentation of the use of / to ensure that all required elements could be documented correctly and thoroughly. The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: - Definition of and appropriate justification for use of and/or during for an emergency safety situation - Revisions/clarifications to the / Policy including: • Who may authorize the use of and/or • Requirement to obtain a physician's order for any use of and/or • Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or • Requirement to fully document each use of and/or • Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention • Requirement to document the names of all staff involved in the and/or	, 2016 , 2016

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N 161	Continued From page 26 Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including that staff documented the date and time the team physician was consulted for the use of a intervention. 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after	N 161	**N 161 Continued** • Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. • Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation • Need to notify the resident's legal guardian that the resident had a and/or and document that notification • Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint/seclusion.	

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N 161	Continued From page 26	N 161	N 161 Continued	

Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes.

Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including that staff documented the date and time the team physician was consulted for the use of a intervention.

2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after

- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / .

- Revisions to the Restraint/Seclusion forms
- Documentation requirements related to /
- Expectations for full compliance to the Restraint/ policy and documentation requirements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 161	Continued From page 26	N 161	N 161 Continued	

Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes.
Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including that staff documented the date and time the team physician was consulted for the use of a intervention.

2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.

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N 161	Continued From page 26 Review on / / of the facility's own video recording revealed Residents #16 and #17 on / / at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on / / revealed evidence of documentation that the resident was admitted to the facility on / /. The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on / accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including that staff documented the date and time the team physician was consulted for the use of a intervention. 2. Review of Resident #17's record on / / revealed that the resident was admitted to the facility on / /. The resident's record documented that the facility sent the resident to a receiving facility on / / accompanied by Law Enforcement officers after	N 161	**N 161 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of /seclusion on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	, 2016 and ongoing

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N 161	Continued From page 27 the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including that staff documented the date and time the team physician was consulted for the use of a intervention. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility, the units were also locked and she inquired whether this was a .	N 161		
N 174	483.364(d) MONITORING DURING AND AFTER A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from . This ELEMENT is not met as evidenced by: Based on record review observation and interview, the facility failed to have a physician or a nurse evaluate the well-being of the residents immediately after the residents were removed from a for 2 of 17 sampled residents reviewed for seclusions and (Resident #16 and #17). The findings included:	N 174	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or	, 2016

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N 174	Continued From page 28	N 174	N 174 Continued	

Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to assess the resident face to face following the ( ) intervention. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies.

Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes.

Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on

- Requirement to fully document each use of and/or
- Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention
- Requirement to document the names of all staff involved in the and/or
- Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L014	A. BUILDING _____ B. WING _____	C 04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 174	Continued From page 28 Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to assess the resident face to face following the ( ) intervention. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on	N 174	N 174 Continued - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /seclusion. The DON and and revised all medical records forms related to the documentation of the use of / to ensure that all required elements could be documented correctly and thoroughly. , 2016 The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: - Definition of and appropriate justification for use of and/or during for an emergency safety situation - Revisions/clarifications to the / Policy including: , 2016	

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N 174	Continued From page 28	N 174	N 174 Continued	

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Review of Resident #16's record on / revealed evidence of documentation that the resident was admitted to the facility on / /. The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on / /

- Who may authorize the use of and/or
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- Requirement to fully document each use of and/or
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N 174	Continued From page 28	N 174	N 174 Continued	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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N 174	Continued From page 29 accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence of documentation a physician or a nurse evaluated the well-being of the resident immediately after the resident was removed from a . 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence of documentation a physician or a nurse evaluated the well-being of the resident immediately after the resident was removed from a . In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a .	N 174	**N 174 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of /seclusion on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed) or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	, 2016 and ongoing
N 178	483.366 NOTIFICATION OF PARENT(S) OR	N 178		

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N 178	Continued From page 30 LEGAL GUARDIAN If the resident is a minor as defined in this subpart: 483.366(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in as soon as possible after the initiation of each emergency safety intervention. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to notify the resident's legal guardians that the residents had a for 2 of 17 sampled residents reviewed for and (Resident #16 and #17). The findings included: Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "notify the resident's parent or guardian of the or , as soon as possible after the initiation of the or . The RN must document this notification to include name of guardian notified, type of notification, RN's signature and date/time of notification." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately	N 178	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and to document that consultation including the date/time of the consult.	, 2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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N 178	Continued From page 31 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence of documentation that the facility notified the resident's guardian of the . 2. Review of Resident #17's record on revealed that the resident was admitted to the	N 178	**N 178 Continued** - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /	

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N 178	Continued From page 31	N 178	N 178 Continued	

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The DON and and revised all medical records forms related to the documentation of the use of / to ensure that all required elements could be documented correctly and thoroughly. , 20:

The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: , 201

- Definition of and appropriate justification for use of and/or during for an emergency safety situation
- Revisions/clarifications to the Restraint/Seclusion Policy including:
  - Who may authorize the use of and/or
  - Requirement to obtain a physician's order for any use of and/or
  - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
  - Requirement to fully document each use of and/or
  - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention
  - Requirement to document the names of all staff involved in the and/or

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N 178 **N 178 Continued**

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N 178	Continued From page 31	N 178	N 178 Continued	

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- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /seclusion

- Revisions to the / forms
- Documentation requirements related to /
- Expectations for full compliance to the / policy and documentation requirements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L014	A. BUILDING _____ B. WING _____	C 04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 178	Continued From page 31 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence of documentation that the facility notified the resident's guardian of the 2. Review of Resident #17's record on revealed that the resident was admitted to the	N 178	**N 178 Continued** Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work. **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of restraint/ on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate.	**, 2016 and ongoing**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 178	Continued From page 32 facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence that the facility notified the resident's guardian of the . In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a .	N 178	**N 178 Continued** For a period of four months, the DON and are conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	
N 188	483.370(a) POST INTERVENTION DEBRIEFINGS Within 24 hours after the use of the or , staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident and by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident	N 188	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include:	, 2016

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N 188	Continued From page 33 and staff the opportunity to discuss the circumstances resulting in the use of or and strategies to be used by the staff, the resident, or others that could prevent the future use of or . This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to conduct a face to face discussion with staff involved in an emergency safety intervention and the resident to include the required discussion requirements for 3 of 17 sampled residents reviewed for and (Resident #14, 16 and #17). The findings included: 1. Review on of the facility's own policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented the resident and staff involved in a / to participate in a debriefing as soon as possible, but no later than 24 hours after the initiation of the or . According to the policies and procedures, "Staff involved in the procedure may be excused from the debriefing if they are no longer on the shift or if their participation is assessed by the nurse to be potentially detrimental to the resident or staff. The resident debriefing sheet will be discussed and completed." Review of Resident #14's record on revealed that the resident had a on from 7:11 PM to 7:16 PM. Further review of the resident's record revealed evidence of	N 188	**N 188 Continued** - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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N 188	Continued From page 33	N 188	N 188 Continued	

and staff the opportunity to discuss the circumstances resulting in the use of or and strategies to be used by the staff, the resident, or others that could prevent the future use of or .

This STANDARD is not met as evidenced by:
Based on record review, observation and interview, the facility failed to conduct a face to face discussion with staff involved in an emergency safety intervention and the resident to include the required discussion requirements for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, 16 and #17).

The findings included:

1. Review on of the facility's own policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented the resident and staff involved in a / to participate in a debriefing as soon as possible, but no later than 24 hours after the initiation of the or . According to the policies and procedures, "Staff involved in the procedure may be excused from the debriefing if they are no longer on the shift or if their participation is assessed by the nurse to be potentially detrimental to the resident or staff. The resident debriefing sheet will be discussed and completed."
Review of Resident #14's record on revealed that the resident had a on from 7:11 PM to 7:16 PM. Further review of the resident's record revealed evidence of

- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /seclusion.
- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of restraint/seclusion.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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N 188	Continued From page 33 and staff the opportunity to discuss the circumstances resulting in the use of or and strategies to be used by the staff, the resident, or others that could prevent the future use of or . This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to conduct a face to face discussion with staff involved in an emergency safety intervention and the resident to include the required discussion requirements for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, 16 and #17). The findings included: 1. Review on of the facility's own policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented the resident and staff involved in a / to participate in a debriefing as soon as possible, but no later than 24 hours after the initiation of the or . According to the policies and procedures, "Staff involved in the procedure may be excused from the debriefing if they are no longer on the shift or if their participation is assessed by the nurse to be potentially detrimental to the resident or staff. The resident debriefing sheet will be discussed and completed." Review of Resident #14's record on revealed that the resident had a on from 7:11 PM to 7:16 PM. Further review of the resident's record revealed evidence of	N 188	**N 188 Continued** The DON and RM reviewed and revised all medical records forms related to the documentation of the use of /seclusion to ensure that all required elements could be documented correctly and thoroughly. The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: - Definition of and appropriate justification for use of and/or during for an emergency safety situation - Revisions/clarifications to the Restraint/Seclusion Policy including: • Who may authorize the use of and/or • Requirement to obtain a physician's order for any use of and/or • Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or • Requirement to fully document each use of and/or • Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention • Requirement to document the names of all staff involved in the and/or	May 4, 2016 , 2016

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N 188	Continued From page 33 and staff the opportunity to discuss the circumstances resulting in the use of or and strategies to be used by the staff, the resident, or others that could prevent the future use of or . This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to conduct a face to face discussion with staff involved in an emergency safety intervention and the resident to include the required discussion requirements for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, 16 and #17). The findings included: 1. Review on of the facility's own policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented the resident and staff involved in a / to participate in a debriefing as soon as possible, but no later than 24 hours after the initiation of the or . According to the policies and procedures, "Staff involved in the procedure may be excused from the debriefing if they are no longer on the shift or if their participation is assessed by the nurse to be potentially detrimental to the resident or staff. The resident debriefing sheet will be discussed and completed." Review of Resident #14's record on revealed that the resident had a on from 7:11 PM to 7:16 PM. Further review of the resident's record revealed evidence of	N 188	**N 188 Continued** • Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. • Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation • Need to notify the resident's legal guardian that the resident had a and/or and document that notification • Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /seclusion.	

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N 188	Continued From page 34 documentation of a resident debriefing that occurred on at 8:00 PM and included only two staff members, a Mental Health Technician and a Registered Nurse. The "Administrative Debriefing" included an additional Registered Nurse and an addition Mental Health Technician. The records documented that the additional Registered Nurse and Mental Health Technician had also participated in the resident's intervention. In an interview conducted on at 1:54 PM with the Risk Manager and the Nurse Manager, the participants acknowledged the findings. 2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double	N 188	**N 188 Continued** • Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of restraint/seclusion. If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. • Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /seclusion - Revisions to the / forms - Documentation requirements related to / - Expectations for full compliance to the / policy and documentation requirements.	

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N 188	Continued From page 35 doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including that the resident and staff debriefing occurred after the . 3. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence that the resident and staff debriefing occurred after the . Further review of Resident #17's record on revealed evidence of documentation that	N 188	**N 188 Continued** Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work. **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate.	, 2016 and ongoing

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N 188	Continued From page 36 the resident had a on . Review of the documentation, in the resident's record revealed two staff members were involved in the ; however, the staff members were documented, "off the unit" and excused from the resident debriefing on at 11:05 AM. The resident's record revealed that both staff members were available and participated to the "Administrative debriefing," on at 12:15 PM, approximately one hour later. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings.	N 188	**N 188 Continued** For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	
N 189	483.370(b) POST INTERVENTION DEBRIEFINGS Within 24 hours after the use of or , all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; This ELEMENT is not met as evidenced by: Based on record review, observation and	N 189	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or	

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N 189	Continued From page 37	N 189	N 189 Continued	

interview, the facility failed to conduct a debriefing session within 24 hours after the use of a and or with the staff involved in the emergency safety and intervention and appropriate supervisory and administrative staff for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, #16 and #17).

The findings included:

1. Review on of the facility's policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented, "All staff involved in placing a resident in or , participants as well as witnesses and appropriate supervisory staff, are included in a staff debriefing discussion of what took place as soon as possible after the incident occurs. The Staff Debriefing Sheet will be completed and discussed no later than 24 hours after the event."

Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a staff/administrative debriefing after the . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings.

2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two

- Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
- Requirement to fully document each use of restraint and/or
- Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention
- Requirement to document the names of all staff involved in the and/or
- Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /

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N 189	Continued From page 37	N 189	N 189 Continued	

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The findings included:

1. Review on of the facility's policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented, "All staff involved in placing a resident in or , participants as well as witnesses and appropriate supervisory staff, are included in a staff debriefing discussion of what took place as soon as possible after the incident occurs. The Staff Debriefing Sheet will be completed and discussed no later than 24 hours after the event."

Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a staff/administrative debriefing after the . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings.

2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two

- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / .

The DON and and revised all medical records forms related to the documentation of the use of / to ensure that all required elements could be documented correctly and thoroughly.

The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on:

- Definition of and appropriate justification for use of and/or during for an emergency safety situation
- Revisions/clarifications to the / Policy including:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

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N 189	Continued From page 37	N 189	N 189 Continued	

interview, the facility failed to conduct a debriefing session within 24 hours after the use of a and or with the staff involved in the emergency safety and intervention and appropriate supervisory and administrative staff for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, #16 and #17).

The findings included:

1. Review on of the facility's policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented, "All staff involved in placing a resident in or , participants as well as witnesses and appropriate supervisory staff, are included in a staff debriefing discussion of what took place as soon as possible after the incident occurs. The Staff Debriefing Sheet will be completed and discussed no later than 24 hours after the event."

Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a staff/administrative debriefing after the . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings.

2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two

- Who may authorize the use of and/or
- Requirement to obtain a physician's order for any use of and/or
- Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
- Requirement to fully document each use of and/or
- Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or the interventions used, and the outcome of the intervention
- Requirement to document the names of all staff involved in the and/or
- Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification

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N 189	Continued From page 37	N 189	N 189 Continued	

interview, the facility failed to conduct a debriefing session within 24 hours after the use of a and or with the staff involved in the emergency safety and intervention and appropriate supervisory and administrative staff for 3 of 17 sampled residents reviewed for and (Resident #14, #16 and #17).

The findings included:

1. Review on of the facility's policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented, "All staff involved in placing a resident in or , participants as well as witnesses and appropriate supervisory staff, are included in a staff debriefing discussion of what took place as soon as possible after the incident occurs. The Staff Debriefing Sheet will be completed and discussed no later than 24 hours after the event."

Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a staff/administrative debriefing after the . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings.

2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two

- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / .
- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of /seclusion. If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /seclusion

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N 189	Continued From page 38 , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence that the staff/administrative debriefing occurred after the .	N 189	**N 189 Continued** - Revisions to the Restraint/Seclusion forms - Documentation requirements related to / - Expectations for full compliance to the /Seclusion policy and documentation requirements. Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work. **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of restraint/seclusion on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate.	

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N 189	Continued From page 39 3. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the (seclusion) intervention in the resident's record, including no evidence that the staff/administrative debriefing occurred after the In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a	N 189	**N 189 Continued** For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	
N 196	483.372(a) MEDICAL TREATMENT FOR INJURIES Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to obtain medical treatment promptly for injuries after for 3 of 17 sampled residents (Resident #7, #14 and #15).	N 196	**Corrective Actions:** The DON reviewed and reaffirmed the policy " and " as accurately addressing the RNs' responsibilities to assess/reassess any resident complaint of injury, determine the extent of the injury, and provide or secure appropriate medical care promptly	, 2016

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N 196	Continued From page 40 The findings include: 1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on . Further review of the resident's record revealed evidence of documentation that a nurse assessed the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated;" the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. There was no evidence of documentation that the nurse determined the extent of all injuries sustained during this and provided or secured the appropriate medical care promptly. The resident was no longer in the facility on 2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse (RN) was conducted at 7:00 PM and the delay was because of an "ongoing crisis on the unit." According to the RN's assessment documentation, there were no injuries noted at that time; however, during the resident debriefing, on at 1:24 PM, the RN documented, "The back of by (sic) ear was ." A "late entry nursing note" for documented that the resident had superficial scratches on the arms. Resident #14 reported in an interview on at 3:26 PM that staff scratched the resident; that the resident sustained scratches from the	N 196	The DON provided training to all RNs on assessment/reassessment of injuries including timeliness of assessment, determining extent of injuries, providing or securing medical care promptly, and documenting all assessments and actions taken. Competency was assessed via post-test. Any RN unable to complete the training by 8 is required to complete training before their next shift. **Monitoring:** The DON/designee monitors 100% of documentation related to the use of / including nursing documentation to assess for adequacy of nursing assessment/reassessment of any complaints of injury and the prompt provision of medical care. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. **Responsible:** Director of Nursing	, 2016 , 2016 and ongoing

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FORM APPROVED
OMB NO. 0938-0391

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N 196	Continued From page 41 , the resident's ear turned purple and stated that staff put ointment on the scratches; however, a review of the resident's record on / / revealed no evidence of documentation related to the treatment. There was no evidence of documentation that the RN determined the extent of all injuries sustained during this and provided or secured the appropriate medical care promptly. 3. Review on / / of Resident #15's record revealed that the resident reported on / / , at the time of discharge from the facility, pain in the back, leg and arms, rated at 4-5 (with 10 being the highest pain on the scale). According to the resident's record, the resident had a physical on / / , but the resident and administrative debriefings were not conducted to assess whether the resident had sustained any injuries at that time. There was no evidence of documentation that the RN determined the extent of all injuries sustained during this and provided or secured the appropriate medical care promptly. In an interview conducted on / at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings for Resident #7, #14 and #15.	N 196		
N 202	483.372(c) MEDICAL TREATMENT FOR INJURIES Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.	N 202	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include:	, 2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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N 202	Continued From page 42 This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to have staff involved in that resulted in injuries meet with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries for 3 of 17 sampled residents who suffered injuries during (Resident #7, #14, and #15). The findings include: 1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on . Further review of the resident's record revealed evidence of documentation that a nurse assessed the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated;" the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. The resident was no longer in the facility on . The resident's record failed to revealed any evidence of documentation that the staff involved in the that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries. 2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse	N 202	**N 202 Continued** - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification	

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N 202	Continued From page 42	N 202	N 202 Continued	

This ELEMENT is not met as evidenced by:
Based on record review and interview, the facility failed to have staff involved in that resulted in injuries meet with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries for 3 of 17 sampled residents who suffered injuries during (Resident #7, #14, and #15).

The findings include:

1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on . Further review of the resident's record revealed evidence of documentation that a nurse assessed the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated;" the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. The resident was no longer in the facility on . The resident's record failed to revealed any evidence of documentation that the staff involved in the that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries.

2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse

- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / .
- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / .

The DON and and revised all , 2016 medical records forms related to the documentation of the use of /seclusion to ensure that all required elements could be documented correctly and thoroughly.

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N 202	Continued From page 42 This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to have staff involved in that resulted in injuries meet with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries for 3 of 17 sampled residents who suffered injuries during (Resident #7, #14, and #15). The findings include: 1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on . Further review of the resident's record revealed evidence of documentation that a nurse assessed the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated;" the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. The resident was no longer in the facility on . The resident's record failed to revealed any evidence of documentation that the staff involved in the that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries. 2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse	N 202	N 202 Continued The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: - Definition of and appropriate justification for use of and/or during for an emergency safety situation - Revisions/clarifications to the / Policy including: • Who may authorize the use of and/or • Requirement to obtain a physician's order for any use of and/or • Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or • Requirement to fully document each use of and/or • Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention • Requirement to document the names of all staff involved in the and/or • Need to consult with the resident's treatment team physician for the and to document that consultation including the date/time of the consult.	8, 2016

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N 202	Continued From page 42	N 202	N 202 Continued	

This ELEMENT is not met as evidenced by:
Based on record review and interview, the facility failed to have staff involved in that resulted in injuries meet with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries for 3 of 17 sampled residents who suffered injuries during restraints (Resident #7, #14, and #15).

The findings include:

1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on . Further review of the resident's record revealed evidence of documentation that a nurse assessed the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated;" the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. The resident was no longer in the facility on . The resident's record failed to revealed any evidence of documentation that the staff involved in the that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries.

2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse

- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint/seclusion.
- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L014	A. BUILDING _____ B. WING _____	C 04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 202	Continued From page 42	N 202	N 202 Continued	

This ELEMENT is not met as evidenced by:
Based on record review and interview, the facility failed to have staff involved in that resulted in injuries meet with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries for 3 of 17 sampled residents who suffered injuries during (Resident #7, #14, and #15).

The findings include:

1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on . Further review of the resident's record revealed evidence of documentation that a nurse assessed the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated;" the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. The resident was no longer in the facility on . The resident's record failed to revealed any evidence of documentation that the staff involved in the that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries.

2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse

- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /
- Revisions to the Restraint/ forms
- Documentation requirements related to /seclusion
- Expectations for full compliance to the / policy and documentation requirements.

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.

Monitoring:

The DON/designees and/or the 100% , 2016 of all documents related to the use of and ongoing /seclusion on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate.

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N 202	Continued From page 43	N 202	N 202 Continued	

(RN) was conducted at 7:00 PM and the delay was because of an "ongoing crisis on the unit." According to the RN's assessment documentation, there were no injuries noted at that time; however, during the resident debriefing, on at 1:24 PM, the RN documented, "The back of by (sic) ear was ." A "late entry nursing note" for documented that the resident had superficial scratches on the arms. Resident #14 reported in an interview on at 3:26 PM that staff scratched the resident; that the resident sustained scratches from the , the resident's ear turned purple and stated that staff put ointment on the scratches. The resident's record failed to reveal any evidence of documentation that the staff involved in that resulted in these injuries met with supervisory staff to evaluate the circumstances that resulted in these injuries and develop a plan to prevent further injuries.

3. 3. Review on of Resident #15's record revealed that the resident reported on , at the time of discharge from the facility, pain in the back, leg and arms, rated at 4-5 (with 10 being the highest pain on the scale). According to the resident's record, the resident had a physical on , but the resident and administrative debriefings were not conducted to assess whether the resident had sustained any injuries at that time. The resident's record failed to reveal any evidence of documentation that the staff involved in these that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries. In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants

For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's seclusion area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly.

Responsible:

Director of Nursing

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N 202	Continued From page 44 acknowledged the findings for Resident #7, #14 and #15.	N 202		
N 222	483.376(f) EDUCATION AND TRAINING Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 9 of 10 sampled direct care employees demonstrated competency in the use of on a semiannual basis This affected 6 of 17 sampled Residents, Resident #1, #7, #14, #15, #16 and #17, who these employees restrained (Employee A, B, C, D, E, F, G, I, and J). The findings included: 1. Review on of the facility's own policies and procedures titled, "Aggressive Behavior Management", with the most recent revision of revealed that "All direct care staff will receive refreshers class every 6 months and will receive education regarding the use of least restrictive measures in effectively managing aggressive residents." Review on of Employee A's personnel file revealed that the employee a Mental Health Technician (MHT) Supervisor received their most recent training related to seclusions and on . 2) Review on of Employee B's personnel file revealed that the employee, a MHT, received	N 222	**Corrective Actions:** The CEO provided written expectations to the Human Resources Director (HRD) regarding compliance with semi-annual training expectations and her responsibilities to ensure that all staff complete refresher training within six months of previous training. The CEO further instructed that any direct care staff not completing training now or in the future in a timely fashion would be suspended until the training has been completed. The HRD/designees completed a 100% audit of all HR files of direct care staff to assess compliance with completion of Behavior Management training which includes the use of and and least restrictive interventions. As a result of that audit, a list of employees requiring refresher training was developed. The scheduled and Residential Manager and Nurse Manager ensured that any direct care employee not current in their semi-annual training related to the use of least restrictive interventions and use of /seclusion were scheduled for extra classes which were held the week of . Any employee not current with training by , have been suspended until they complete the course. Training documentation is maintained in each employee's training file. The HRD submitted to the CEO verification of the completion of training for all staff requiring training related to the least restrictive interventions and the use of and/or	, 2016 , 2016 8, 2016 8, 2016

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 222	Continued From page 45 their most recent training related to seclusions and on . Review on of Resident #15's record revealed that this employee performed a physical on the resident, documented as a personal prone from on from 4:18 PM to 4:20 PM. 3) Review on of Employee C's personnel file revealed that the employee, a MHT Supervisor, received their most recent training related to seclusions and on . Review on of Resident #17's record revealed that the employee performed a physical on the resident, documented as a personal vertical on , from 7:55 PM to 7:55 PM, less than one minute. 4) Review on of Employee D's personnel file revealed that the employee, a MHT, received their most recent training related to seclusions and on . Review on of Resident #17's record revealed that the employee performed a physical on the resident, documented as a personal vertical on , from 10:22 AM to 10:23 AM. Review on of Resident #7's record revealed that the employee performed a physical on the resident, documented as a personal horizontal on , from 5:33 PM to 5:48 PM. 5) Review on of Employee E's personnel file revealed that the employee, a MHT, received their most recent training related to seclusions and on . 6) Review on of Employee F's personnel file revealed that the employee, a MHT, received the most recent training related to seclusions and	N 222	**Monitoring** The HRD submits a monthly report to the CEO and Senior Leadership of any staff member not in compliance with training requirements that have been suspended pending completion of training and staff members requiring completion of training in the upcoming month. An aggregated summary is provided to the Governing Body on a quarterly basis. **Responsible:** Human Resources Director	, 2016 and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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N 222	Continued From page 46 on . 7) Review on of Employee G's personnel file revealed that the employee, a MHT Supervisor, received their most recent training related to seclusions and on . Review on of Resident #17's record revealed that the employee performed a physical , documented as a personal vertical on the resident on from 3:45 to 3:48 PM. Review on of Resident #1's record revealed that the employee performed a physical on the resident, documented as a personal vertical on //16, from 12:50 PM to 12:51 PM and a personal horizontal from 12:58 PM to 12:59 PM. Review on of Resident #16's record revealed that the employee performed a physical on the resident, documented as a personal prone on , from 3:55 PM to 4:07 PM. 8) Review on of Employee I's personnel file revealed that the employee, a MHT, received their most recent training related to seclusions and on . 9) Review on of Employee J's personnel file revealed that the employee, a MHT, received their most recent training related to seclusions and on . Review on of Resident #14's record revealed that the employee performed a physical , documented as a personal horizontal on the resident on , from 11:46 AM to 11:47 AM; performed a physical , documented as a personal prone on the resident on from 10:30 AM to 10:35 AM. In an interview conducted on /16 at 2:51 PM	N 222		

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N 222	Continued From page 47 with the facility's Human Resource Manager, the Human Resource Manager acknowledged the findings.	N 222		

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

FED-EX OVERNIGHT 8086 3829 3602
SIGNATURE REQUIRED

, 2016

Administrator
Sandy Pines
11301 S.E. Tequesta Terrace
Tequesta, FL 33469

RE: CCR# 2016003021

Dear Administrator:

This letter reports the findings of a complaint survey of your facility commenced on , 2016 and concluded on , 2016 by a representative of this office. It was determined the Residential Treatment Facility for Children and Adolescents was not in compliance.

The following Conditions of Participation were Not Met:

Fed - N - 0100 - 483.354 - Use Of And
Fed - N - 0125 - 483.356 (a) - Protection Of Residents
Fed - N - 0140 - 483.358(a) - Orders For Use Of Or
Fed - N - 0145 - 483.358(f) - Orders For Use Of Or
Fed - N - 0149 - 483.358(h) - Orders For Use Of Or
Fed - N - 0152 - 483.358(h)(3) - Orders For Use Of Or
Fed - N - 0153 - 483.358(h)(4) - Orders For Use Of Or
Fed - N - 0154 - 483.358(h)(5) - Orders For Use Of Or
Fed - N - 0155 - 483.358(i) - Orders For Use Of Or
Fed - N - 0160 - 483.360 - Consultation With Treatment Team Physician
Fed - N - 0161 - 483.360(b) - Consultation With Treatment Team Physician
Fed - N - 0174 - 483.364(d) - Monitoring During And After
Fed - N - 0178 - 483.366 - Notification Of Parent(s) Or Legal Guardian
Fed - N - 0188 - 483.370(a) - Post Intervention Debriefings
Fed - N - 0189 - 483.370(b) - Post Intervention Debriefings
Fed - N - 0196 - 483.372(a) - Medical Treatment For Injuries
Fed - N - 0202 - 483.372(c) - Medical Treatment For Injuries
Fed - N - 0222 - 483.376(f) - Education And Training

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction, Form CMS 2567, which references all of the deficiencies.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

You must provide the Agency with an acceptable Plan of Correction (PoC) for all deficiencies cited **within ten calendar days** from receipt of the Statement of Deficiencies and Plan of Correction, Form CMS 2567. Please complete a Plan of Correction (PoC) for the deficiencies, including the date corrective action was accomplished or is anticipated to be accomplished. Please sign and date page 1 on the bottom and return to this Field Office within ten calendar days of receipt of this faxed report. Failure to submit a reply within this time frame may jeopardize your certification status. **All deficiencies must be corrected no later than , 2016.**

In order for a PoC to be acceptable, it must include the following elements:
Core Elements of PoC:

- How the corrective action will be accomplished for individuals found to have
- been affected by the deficient practice;
- How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;
- What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; and
- When corrective action must be accomplished.

Be advised that the Agency is recommending termination of your Medicaid participation to be effective , 2016 which is 90 days from the date of the survey. The termination process provides an opportunity for you to make corrections and achieve compliance. A revisit will be conducted within 45 days of the survey if a PoC is received and accepted. The revisit will determine if your facility is in compliance with the Conditions of Participation.

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. If you have questions, please contact this office at (561) 381-5840.

Sincerely,

Arlene Mayo-D is
Field Office Manager

AMD
Enclosure: CMS Form 2567

EESW